Male Participation on Women Reproductive Health: Insight from Mizoram

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Abstract—*The word ''Reproductive Health'' implies both men and women. Men are partners in reproduction and sexuality. It is "a state of complete physical, mental and social well-being, and not merely absence of disease or infirmity, in all matter relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (ICPD, 1994). Male involvement is central to improving reproductive health and process to achieving gender equity. Studies show that when men are provided with information about reproductive health issues, they are likely to be increasingly supportive of their partner's family planning decisions.*

Male participation is a crucial component in the optimization of Maternal and Child Health (MCH) services. Comprehensive male involvement in women's reproductive health includes encouraging men to become more involved and supportive of women's needs, choice and rights in sexual and reproductive health: and addressing men's own sexual and reproductive health needs and behaviour.

Methodology

The study on male's participation in women reproductive health was conducted in southern Mizoram, 2014. Using mixed approach, the quantitative data is collected from 250 wives respondents. Qualitative information elicited through focus group discussion (FGDs) and key informant interviews (KIIs). It examined men's knowledge, awareness and perceptions on women's reproductive health issues including family planning.

Findings

The findings of the study show the relationship between the male involvement and the status of women's reproductive health. The knowledge and awareness level of the husband is reflected in reproductive health seeking behaviour of the wife and finally the economic condition of the family by and large, pronounced the level of male participation in women's reproductive health.

Keywords: *Male involvement / male participation, women's reproductive health, gender equality, gender roles, family planning*

1. INTRODUCTION

Reproductive health is a crucial part of general health and is a central feature of human development. In many cultures, the discrimination against girls and women that begins in infancy which determine the trajectory of lives. The male attitudes towards gender and sexual relations arise in boyhood, when they are often set for life. Male involvement in reproductive health is a complex process of social and behavioural changes that is needed for men to play more responsible roles in reproductive health (Drennan, 1998).So, male involvement is central to improving reproductive health and to the incremental process of achieving gender equity.

The first strategy on reproductive health adopted on May 2004, in the 57th World Health Assembly, WHO aims to accelerate progress towards meeting the Millennium Development Goals and reproductive health goals of the ICPD. The strategy identifies five priority aspects of reproductive and sexual health: Improving antenatal, delivery, postpartum and newborn care; Improving high-quality services for family planning, including infertility services; eliminating unsafe abortion; Combating STIs, including HIV, reproductive tract infections, cervic cancer and other gynecological morbidities; Promoting sexual health

Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes (ICPD, 1994). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. A reproductive right embraces certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

1.1 India and Women Reproductive Health

Women in India occupy a relatively low economic and social status in the family thus leading to discrimination in their access to food and nutrition, health care and education. Pregnancy may accentuate both physical and verbal violence if husband does not want the child, or suspect that his wife is

unfaithful to him. Violence is a way of demonstrating his power over her (Visaria et al, 2011).

The rapidly growing population had been a major concern for health planners and administrators in India to the launching of National Family Planning (NFP) Programme by the Government of India (GoI). Thus, India is the first country to have taken up the family planning programme at the national level and renamed as 'Target Free Approach' on 1st April, 1996. In the ninth five year Plan the Government of India (GoI) introduced Reproductive & Child Health (RCH) package to supplement the Maternal Child Health (MCH) services within the entire country in subsequent to the ICPD, Cairo 1994. The Reproductive Child Health (RCH) Programme –I was launched in the year 1997-98 and the second phase of RCH -II was also started on 1st April, 2005 with an aim to increase the couple protection rate and coverage. The main focus of the programme is to reduce infant (IMR), child and maternal mortality (MMR) rates. The RCH-II, envisaged an operation of 24-hour delivery centres that would responsible for providing basic emergency obstetric care and essential new-born care. With similar objective, the National Maternity Benefit Scheme renamed as Janani SurakshaYojana (JSY) was introduced on 12th December, 2005.

1.2 Issues on Reproductive Health

In understanding of the challenges faced by women in reproductive health care, WHO (2001) shows that there were more than 340 million cases of curable sexually transmitted infections (STDs) in each year at a global level and half of the infections are among men (Jones, Wasserheit, 1991). In addition, women are not only vulnerable biologically to be infected, but social and cultural norms also compel them to damage their health (Hawks et al., 2001). Further, the widespread prevalence of sexually transmitted Infections (STIs) and reproductive tract infections (RTIs) was nearly 6% in the age group of 15years - 50years in the nationwide community based study. Cecilia B, 1993, study on the women life circle, India accounted for 15 % of the world's entire population and represent 25 % of the world's maternal deaths and it also further indicated that about 30% of Indian women are married between the ages of 15years -19years. In addition, maternal deaths account for about 1% of all deaths and 2% of all female deaths annually. This has translated into over 10% of all deaths to women of reproductive age and 13.2 % among rural women in 1987 (UNICEF, 1991). A large proportion of these deaths, up to two-thirds by some accounts are preventable (Agarwal et al., 1982; BhaskarRao, 1980; Pant and Mehendale, 1987; Roy Chowdhury et al., 1982; Mitra and Khara, 1983; Sinha, 1986; Bhatia, 1988). In contrast, abortion-related deaths constitute about 4% of maternal deaths in the United States (Chang et. al., 2003). However, the Indian population has continued to grow by approximately 2% annually and has more than doubled in size, from 439 million in 1961 to an estimated 930 million in 1996. Seven out of every 100 children born in India die before reaching age one (Dyson et al. 2004), and approximately five out of every 1,000 pregnant women die due to causes related to pregnancy and childbirth (MOHFW 2005).

1.3 Determinant to reproductive health

The socio-cultural determinants of reproductive health have a cumulative effect over a lifetime. A correlation exists between the social inequity and reproductive health. The female literacy rate in India is 54.3% (Census, 2001) and 26.1% of the total population in India are below the poverty line (CBHI, 2002). Poverty and illiteracy have a negative bearing on the maternal and child health. About one third of women are married by the age of 15 years and two-third by 18 years. Thus, the median age at first birth is 19.6 years (NFHS-2). Hence, half of all the Indian women experience child birth by the time they are 19, usually before the physical maturity is obtained. The epidemiological literature demonstrates a relationship between community-level socioeconomic context and numerous health outcomes, including mortality rates, self-rated health, cardiovascular disease, and chronic conditions (Robert, 1999).

Firstly, education can have an empowering effect on women, broadening their horizons, choices, and opportunities and "enabling women to take personal responsibility for their health and for that of their children" (Paul and Rumsey, 2000). Higher levels of maternal and head of household education are associated with increased use of healthcare during pregnancy as well as having modern a delivery or a delivery by trained personnel (Bhatia and Cleland, 1995; Celik and Hotchkiss, 2000; Hotchkiss, 2001; Navaneetham and Dharmalingam, 2002; Obermeyer and Potter, 1999; Paul and Rumsey, 2002; Pebley et al., 1996) across socio-economic and cultural contexts (Naveneetham and Dharmalingam, 2002). The NFHS-I, World Fertility Survey (WFS) and the Demographic and Health Surveys, show that even after controlling the effect of other factors, education is a key factor influencing contraceptive use (Rutherford and Ramesh, 1996; Ramesh et al, .1996; Boerma et al., 1990; Bicego and Boerma, 1993; Caldwell and Caldwell, 1990; Hobcraft,; Murthi, 1995).

Secondly, electronic media can be an important source of information regarding the benefits of preventive care for maternal health (Navaneetham and Dharmalingam, 2002; Stephenson and Tsui, 2002). They suggested that exposure to electronic media can influence cultural barrier to using modern healthcare. Further, radio and telecommunications can clearly help in emergencies and with early diagnosis and referral. They can also help improve the management of the health transport system and its efficiency.

Thirdly, the geographical barriers such as mountainous terrain or poor road conditions also delay access to maternal healthcare. In Haiti road conditions and geography constrain access to both prenatal care and delivery care for women

living in rural areas was not good (Guttmacher Institute, 2007).

2. METHODOLOGY.

The study on male's participation in women reproductive health was conducted in southern Mizoram, 2014. Using mixed approach, the quantitative data is collected from 250 wives respondents to understand the perception of women on male participation in the reproductive health care. Qualitative information elicited through focus group discussion (FGDs) and key informant interviews (KIIs). It examined men's knowledge, awareness and perceptions on women's reproductive health issues including family planning.

3. FINDINGS.

The profile of the respondents was presented in the three sub-section viz geographical location, age at marriage and educational level. All the respondents were residing in Lawngtlai district, Mizoram. The table has shown that 51% of the respondents were belonging to urban areas and another 49% belong to rural areas.

Table 1: Respondents Status

Sl.no	Categories	Percent
1.	Geographical location	
	Rural	51
	Urban	49
2.	Age at marriage	
	Below 18 years	29.2
	19-23 years	55.2
	24-28 years	8.3
	29-33years	2.1
	34-38 years	4.2
	39-43 years	1.0
3.	Education	
	Illiterate	13.5
	Below middle	34.4
	Below high school	31.3
	Higher secondary	11.5
	Graduate	7.3
	Post-graduate	2.1

Source: Computed

The data had shown that more than half (55.2%) of the respondents have married at the age between 19years to 23years old. Unfortunately, 29.2% of the respondent got married before attainment of 18years of age. Also, another 8.3% of the respondent was married between the age of 24years to 28years old and 4.2% of the respondents was married in the age group between 34years to 38years, and it followed by 2.1% of the respondent was married only when they were at the age between 29years to 33years. Thus, 1.0% of the respondents had married between 39years to 43years of age.

The educational standard of the respondents has a connection with the reproductive health status. So, the educational qualification of the respondents shows that a maximum of 34.4% of the respondents had not completed standard VII, followed by 31.3% of the respondents who do not complete their matriculation. Another 11.5% of the respondents studied up to class XII and only 10 % of the respondents graduated including post-graduation. However, the most challenging part of the study is that as high as 13.5% of the women respondents were illiterate who has not once go to school nor having basic education

2.3 Family Planning

India is the second most populous country in the world after china. In spite of concrete steps and efforts taken by the government of India to monitor the rapid growth rate, the population of the nation could not yet be stabilized. Unintended pregnancies account for nearly 50% of all pregnancies in the U.S. There is a link between unwanted pregnancies and many health and social problems including: inability to complete education, poverty and becoming dependent on the welfare system, poor health and mental health problems, neglect, abuse and family violence. These health and social problems affect not only pregnant women, but also their children, partners and families. So, the family planning component has been placed on the highest priority under integrated health and family welfare services provided through primary health care centre.

The sections present the knowledge of women about the family planning methods i.e., pills, Cu-U, injection, condom and sterilization. The table shows a wide difference in the knowledge level of the respondents both belonging to rural and urban area were: understand of family planning, couple decision on family planning, contraceptive use is harmful, consulted doctor/nurse in using method, ever attended campaign on contraceptive use and major complaint for not adopting family planning.

The understanding of family planning is varying among the respondents. The table has shown that 61.5% of the respondents had known to adopt contraceptives methods and another 34.4% of the respondents were understands of spacing of birth. Also, 2.1% of the respondents were giving the time of birth. However, another 2.1% of the respondents had not attempted the inquiry.

While, it is important to note that, men's participation is essential to facilitating women to avoid unintended or unwanted pregnancies. So, the participation of men in the family planning reflects the knowledge and education compounded on reproductive health of women. Therefore, the education of the husband is highly sensible on reproductive health care of women. The data has shown that 66.7% of the respondents have discussed family planning with their spouse and another 33.3% of the respondents felt that there was no need for discussion between the couple. Also, two third of the

respondents had the knowledge of contraceptive methods; importance of men's attitude towards contraceptive methods and men's involvement in family planning.

Table 2. Knowledge and practice of Family Planning

Sl.no	Indicators	Per cent
1.	Understand of family planning	
	Birth control	34.4
	Use of contraceptive	61.5
	Spacing of birth	2.1
	No response	2.1
2.	Couple decision on Family Planning	
	Yes	66.7
	No	33.3
3.	Harmful of Contraceptive Use	
	Yes	51.0
	No	47.9
	No response	1.0
4.	Consult Doctor/nurse in using method	
	Yes	22.9
	No	57.3
	No response	19.8
5.	Attended awareness on contraceptive use	
	Yes	24.0
	No	75.0

Source: Computed

The above table presents the adoption of contraceptive methods is harmful by the respondents. Nearly two third (51.0%) of the respondents had reported that the practiced of contraceptive methods is harmful for the health of the mothers. Whereas, the remaining one third (47.9%) of the respondents has reported the use of contraceptive method is not harmful.

The table is presenting the consultation of health care providers such as doctor/nurse/workers by the respondents. Out of 96 respondents, 57.3% of the respondents had taken contraceptive pill without consultation of doctor/ nurse/ health worker, meanwhile 22.9% of the respondents had consulted doctor /nurse/health worker before use. Thus, the remaining 19.8% of the respondents had not attempted.

Apart from the data that had been collected, most of the people asserted that since they hardly get any information from the health workers, there is less improvement on the awareness of reproductive health care. The above table shows that 75.0% of the respondents had never attend awareness programme on contraceptive methods and revealing the absence of such intervention especially in rural part of Lawngtlai district. However, one fourth of the respondents received such awareness in their community.

2.4 Male Participation in Women Reproductive Health Care

The husband's involvement in the wife's reproductive health became matter of concern. The study of this section is to carry out men's participation in the reproductive health care, viz, maternal, child health care and family planning etc. Traditionally, men are more powerful in most societies and decision making is exercised more often by men. So, men have also an important role in decision making in anti natal check-up, place of delivery and types of attendants to be consulted.

The table presents the husband decision on the number of children and 68.8% of the respondents had reported the number of child to be held and or number of birth to be given by the wife was not decided by husband. While, 31.3% of the respondents have reporting the husband have decision with the number of children.

Table 3: Men's Involvement on Reproductive Health

Sl.no	Categories	Per cent
1.	Decision of husband on numbering in children	
	Yes	31.3
	No	68.8
2.	Suggested for institutional delivery	
	Yes	57.3
	No	42.7
3.	Advice given during pregnancy	
	Self-healthcare	87.5
	Caring of children	5.2
	Family problem	7.3
4	Men accompany in the Antenatal check up	
	Yes	47.9
	No	52.1
5.	Involvement in household activities	
	Yes	96.9
	No	3.1
6.	Spouse participation in child care	
	Yes	39.6
	No	60.4

Source: Computed

The other way of viewing men's participation in this aspect is the presence of husband and participation since inception throughout the prenatal care, natal and even on post natal care. Receiving advice for institutional delivery is expected out of men participation and 57.3 % of the respondent's husbands prefer and suggested institutional delivery. However, another 42.7% of the respondents had never received such advice from their spouse. Also, 87.5% of the respondents reported that the main advice received from the husband was to take proper health care and while 7.3% of them received advice related to family problems. Interestingly, 5.2% of the respondents had reported that they often received the husband's concern on the child health care. In addition, the data has shown that half of the respondents had never received accompany of the husband in the antenatal check-up mainly due to the away of the husband to work. However, nearly half of the respondents were accompanied by the spouse in the check-up. Thus, the above table has shown that majority of the respondents had reported the husband helped them out in household activities. The remaining 3.1% of the respondents had never received helped from spouse on household activities. Lastly, the

examination on the involvement of husbands in the treatment of children shows than one-third of the respondents were supported in the health care of children. However, 60.4% of the respondents reported that the responsibilities were solely taken by the wife and the husband never involve in seeking the treatment of children.

4. CONCLUSION.

The findings of the study on male participation on women reproductive health show the relationship between the level of male involvement and the status of women's reproductive health. The knowledge and awareness level of the husband is reflected in the spouse reproductive health seeking behaviour. Besides the perceptions on husband, the wives knowledge and awareness on their own reproductive health became a matter of concern. Many of the respondents has adopted family planning methods without medical consultation and also giving their first birth before attaining 18 years of age. The qualitative information talks about that the female herself is taking-up responsibility during pregnancy, child birth, and post natal care and even for child care. Meanwhile, it is worthy to note that the level of husband's involvement in the wife reproductive health is condition by the economic status of the family by and large. In conclusion, the gender discrimination, gender in equality and the women empowerment status is reflected and pronounced even in the reproductive health of women.

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